GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA MEDICAID FEE-FOR-SERVICE
ONCOLOGY, ORAL - HEMATOLOGIC PA SUMMARY

Preferred	Non-Preferred
Bosulif (bosutinib) Brukinsa (zanubrutinib) Calquence (acalabrutinib) Farydak (panobinostat) Iclusig (ponatinib) Idhifa (enasidenib) Imbruvica (ibrutinib) Inrebic (fedratinib) Mercaptopurine tablets generic* Ninlaro (ixazomib) Pomalyst (pomalidomide) Revlimid (lenalidomide)* Rydapt (midostaurin) Sprycel (dasatinib) Tasigna (nilotinib) Thalomid (thalidomide)* Venclexta (venetoclax) Xpovio (selinexor) Zolinza (vorinosta) Zydelig (idelalisib)	Purixan (mercaptopurine suspension)

*PA not required

LENGTH OF AUTHORIZATION: 1 year

NOTES:

- Mercaptopurine generic, Revlimid and Thalomid do not require prior authorization.
- Special consideration taken for members with stage IV advanced metastatic cancer.

PA CRITERIA:

Bosulif

- Approvable for members with a diagnosis of chronic-phase Philadelphia chromosome-positive (Ph+) chronic myelogenous leukemia (CML).
- Approvable for members with a diagnosis of accelerated- or blast-phase Ph+ CML who are resistant or intolerant to imatinib (Gleevec), dasatinib (Sprycel) or nilotinib (Tasigna).
- Approvable for members with a diagnosis of Ph+ acute lymphoblastic leukemia (ALL) who are resistant or intolerant to imatinib (Gleevec), dasatinib (Sprycel) or nilotinib (Tasigna).

Brukinsa

- Approvable for members with a diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy.

Calquence

- Approvable for members with a diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy.
- Approvable for members with a diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL).

Farydak

- Approvable for members with a diagnosis of multiple myeloma who have been previously treated with at least 2 prior therapies, including bortezomib (Velcade) and an immunomodulatory agent (lenalidomide [Revlimid], thalidomide [Thalomid], pomalidomide [Pomalyst])
- Farydak must be given in combination with bortezomib (Velcade) and dexamethasone, with lenalidomide (Revlimid) and dexamethasone or with carfilzomib [Kyprolis].

Iclusig

- Approvable for members with a diagnosis of chronic (not newly diagnosed), accelerated or blast-phase CML who are resistant or intolerant to imatinib (Gleevec), bosutinib (Bosulif), dasatinib (Sprycel) and nilotinib (Tasigna).
- Approvable for members with a diagnosis of Ph+ ALL who have the T3151-postive BCR-ABL mutation or who are resistant or intolerant to imatinib (Gleevec), dasatinib (Sprycel) and nilotinib (Tasigna).

Idhifa

- Approvable for members with a diagnosis of relapsed or refractory acute myeloid (myelogenous) leukemia (AML) who have an isocitrate dehydrogenase-2 (IDH2) mutation as detected by a Food Drug Administration (FDA)-approved test or other validated test performed in a Clinical Laboratory Improvement Amendments (CLIA)-approved facility.

Imbruvica

- Approvable for members with a diagnosis of mantle cell lymphoma (MCL) who have received at least one prior therapy.
- Approvable for members with a diagnosis of chronic lymphocytic leukemia (CLL)/small lymphocytic lymphoma (SLL).
- Approvable for members with a diagnosis of Waldenstrom's macroglobulinemia.
- Approvable for members with a diagnosis of marginal zone lymphoma (MZL) who require systemic therapy and have received at least one prior anti-CD20-based.
- Approvable for members with a diagnosis of chronic graft versus host disease (cGVHD) who are a previous recipient of an allogeneic hematopoietic stem cell transplant and have experienced ineffectiveness, allergy, contraindication, drug-drug interaction or intolerable side effect with corticosteroid therapy.
- Approvable for members with a diagnosis of diffuse large B-cell lymphoma who have progressed on first-line therapy and are not a candidate for high-dose therapy.

Inrebic

- Approvable for members with a diagnosis of intermediate-2 or high-risk primary or secondary (post-polycythemia vera or post-essential thrombocythemia) myelofibrosis (MF) who are not a transplant candidate and have a platelet count $\geq 50 \times 10^9$/L.

Ninlaro

- Approvable for members with a diagnosis of multiple myeloma who have been previously treated with at least 1 prior therapy
- Ninlaro must be given in combination with lenalidomide (Revlimid) and dexamethasone.

Pomalyst

- Approvable for members with a diagnosis of multiple myeloma who have been previously treated with at least 2 prior therapies, including lenalidomide (Revlimid) and bortezomib (Velcade)
- Member must have experienced disease progression on or within 60 days of completion of the last therapy.
- Pomalyst must be given in combination with dexamethasone unless the member is steroid intolerant.
- Prescriber, pharmacy, and member must be enrolled in the Pomalyst REMS program.

Purixan

- Approvable for members with a diagnosis of acute lymphoblastic leukemia (ALL), acute myelogenous leukemia (AML) or chronic myelogenous leukemia (CML) who are unable to swallow solid oral dosage forms or require a dose that is not obtainable with mercaptopurine tablets.

Rydapt

- Approvable for members with a diagnosis of newly-diagnosed acute myeloid leukemia (AML) who have an FLT3 mutation as detected by a Food and Drug Administration (FDA)-approved test or other validated test performed in a Clinical Laboratory Improvement Amendments (CLIA)-approved facility when used in combination with cytarabine and daunorubicin induction as well as cytarabine consolidation chemotherapy.
- Approvable for members with a diagnosis of advanced or aggressive systemic mastocytosis (ASM), systemic mastocytosis with associated hematological neoplasm (SM-AHN) or mast cell leukemia (MCL).

Sprycel

- Approvable for members with a diagnosis of chronic-phase Ph+ CML.
- Approvable for members with a diagnosis of accelerated- or blast-phase Ph+ CML who are resistant or intolerant to imatinib (Gleevec), bosutinib (Bosulif) or nilotinib (Tasigna).
- Approvable for members with a diagnosis of Ph+ acute ALL.
- Approvable for members with a diagnosis of gastrointestinal stromal tumor (GIST) who are resistant or intolerant to imatinib (Gleevec), sunitinib (Sutent) or regorafenib (Stivarga).

Tasigna

- Approvable for members with a diagnosis of chronic-phase Ph+ CML.
- Approvable for members with a diagnosis of accelerated-or blast-phase Ph+ CML who are resistant or intolerant to imatinib (Gleevec), bosutinib (Bosulif) or dasatinib (Sprycel).
- Approvable for members with a diagnosis of Ph+ acute ALL.
- Approvable for members with a diagnosis of GIST who are resistant or intolerant to imatinib (Gleevec), sunitinib (Sutent) or regorafenib (Stivarga).

Venclexta

- ❖ Approvable for members with a diagnosis of chronic lymphocytic leukemia (CLL) or small lymphocytic lymphoma (SLL) when the member has disease progression after at least one prior therapy.
- ❖ Approvable for members 74 years of age or younger with newly diagnosed acute myeloid (myelogenous) leukemia (AML) when used in combination with azacitidine, decitabine or low dose cytarabine who have a comorbidity that precludes use of intensive induction chemotherapy.
- ❖ Approvable for members 75 years of age or older with newly diagnosed AML when used in combination with azacitidine, decitabine or low dose cytarabine.

Xpovio

- ❖ Approvable for members with a diagnosis of relapsed or refractory multiple myeloma who have been previously treated with at least 4 prior therapies, including at least 2 proteasome inhibitors, at least 2 immunomodulatory agents and an anti-CD38 monoclonal antibody
- ❖ Xpovio must be given in combination with dexamethasone unless the member is steroid intolerant.

Zolinza

- ❖ Approvable for members with a diagnosis of progressive, persistent or recurrent cutaneous manifestations of cutaneous T-cell lymphoma (CTCL) in members who have received at least two previous systemic therapies.

Zydelig

- ❖ Approvable for members with a diagnosis of chronic lymphocytic leukemia (CLL) who have relapsed after or are refractory to at least one prior therapy when used in combination with Rituxan (rituximab).
- ❖ Approvable for members with a diagnosis of follicular lymphoma (FL) or marginal zone lymphoma (MZL) (B-cell non-Hodgkin lymphomas) who have relapsed after or are refractory to at least two prior therapies.
- ❖ Approvable for members with a diagnosis of small lymphocytic lymphoma (SLL) who have relapsed after or are refractory to at least two prior therapies.

EXCEPTIONS:

- Exceptions to these conditions of coverage are considered through the prior authorization process.
- The Prior Authorization process may be initiated by calling **OptumRx at 1-866-525-5827.**

PREFERRED DRUG LIST:

- For online access to the Preferred Drug List (PDL), please go to http://dch.georgia.gov/preferred-drug-lists.

PA and APPEAL PROCESS:

- For online access to the PA process, please go to www.dch.georgia.gov/prior-authorization-process-and-criteria and click on Prior Authorization (PA) Request Process Guide.

QUANTITY LEVEL LIMITATIONS:

- For online access to the current Quantity Level Limits (QLL), please go to www.mmis.georgia.gov/portal, highlight Pharmacy and click on Other Documents, then select the most recent quarters QLL List.